500-81-0053

3075-3 May 1982

Data Base Completion Report

Cathy L. Carlson

THE URBAN INSTITUTE
2100 M Street, N.W.
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Project Report

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Opinions expressed are those of the author and do not necessarily represent the views of The Urban Institute or its sponsors.

Contract Information

Contract no.:	HCFA-500-81-0053
Type and amount of award:	Competitive, $287,557.00
Awarded by:	ORDS, HCFA, HHS Contract Branch, Area D-2, GOB 6325 Security Blvd. Baltimore, MD 21207
Project Officer:	James R. Cantwell
Project Director:	Jack Hadley

California Medicare - Medicaid Claims Files

Type of Scale: Charge-Based

This longitudinal Urban Institute data base includes information on Medicaid and Medicare claims filed for services performed by a sample of 7,000 California physicians. All claims processed in the first quarter of each of the five years 1974-1978 are included. All procedures are identified by the applicable California Relative Value Scale code. The physician's average charge and average amount reimbursed are available for each procedure.

Strengths and Limitations

This data base has two compelling advantages for use in developing a charge-based RVS. The first is that it exists in fully processed form at the Urban Institute. The acquistion and compilation of this data, which cost over $200,000 is complete. The second is the level of detail and accuracy of the data itself. Because the source is actual claims, rather than a survey, the charge values are derived on a service by service basis and represent actual fees, rather than a standard quoted charge. Because the claims data are routinely reported and required for reimbursement they are of high quality. The claims cover all services provided by physicians and outside services which are billed through the physician. The one fault of this data base is its limited (California only) geographic coverage.* These data have been compiled by physician and procedure.

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*Data similar to those available for California could be obtained for other geographic areas and/or for privately insured claims. The costs of obtaining and using additional data and the type of information available would be heavily dependent on the carrier chosen as a source.

Physician Procedure File

This file is a compilation of the claims data by physician, procedure and year. For 1978 there are approximately 139,000 physician-procedure combinations. Although more than 30 specialties are included in the file, over half of the physician-procedure combinations are accounted for by the general practitioners, internists, general and orthopedic surgeons and ophthalmologists. The physician sample includes three types of providers: new solo practitioners (licensed since 1972), established solo practitioners, and group practices. Both office-based and hospital based physicians are represented.

For each physician-procedure combination the average charge, the average amount reimbursed and the number of times the procedure was performed is available for four patient categories: Medicaid eligible, joint Medicaid-Medicare eligible, Medicare assigned and Medicare non-assigned. Also included are the Medicare customary and prevailing charges and the Medicare and Medicaid CRVS values. The customarys and prevailings provide further information on the distribution of charges.

All providers' locations are identified by county and PSRO. The physician's age, date of licensure and medical school is available for solo practitioners only.

HCFA Medicare Prevailing Charge Survey

Type of Scale: Charge-Based

The Medicare Prevailing Charge Survey consists of information provided by Medicare intermediaries on physician charges for 100 high volume Medicare procedures. The 1981 fee screen year data have unadjusted 50th and 75th percentile charges as well as the adjusted prevailing charges. These values are available for the over 200 areas (states or portions of states) which are deemed Medicare reimbursement localities. The data are based on charges by members of the specialty most likely to perform the procedure. For thirty procedures general practitioners' charge data are also available.

Strengths and Limitations

The Medicare Prevailing Charge data have several characteristics which are advantageous for the development of a charge-based RVS. The data are national in scope and available annually. The 100 procedures are identified by CRVS codes, providing precise designations for purposes of comparison across scales. Each carrier specifies the type of claims used in developing prevailing charges: Medicare only, Medicare and Medicaid, or both public and private. Thus, the effect of the composition of the claims base on the RVS can be investigated. The 1979 and 1980 Prevailing Charge files are currently in use at the Urban Institute, the 1981 file is on order from HCFA. The major disadvantage of this data base is that the 100 procedures covered, although high volume, may not be those of greatest interest for the evaluation of charge-based RVSs.

A listing of the procedures included on the 1979 file, and the specialties to which the charge data apply follows.

Initial Brief Office Visit	Internist
Initial Limited Office Visit	GP, Internist
Initial Intermediate Office Visit	Internist
Initial Comprehensive Office Visit	GP, Internist
Minimal Followup Office Visit	GP, Internist
Brief Followup Office Visit	GP, Internist
Limited Followup Office Visit	GP, Internist
Intermediate Followup Office Visit	GP, Internist
Extended Followup Office Visit	GP, Internist
Comprehensive Followup Office Visit	GP, Internist
Brief Followup Home Visit	GP, Family Practitioner
Limited Followup Home Visit	Family Practitioner
Intermediate Followup Home Visit	GP, Family Practitioner
Extended Care Facility Visit	Internist
Brief Followup Nursing Home Visit	GP, Internist
Initial Brief Hospital Visit	GP, Internist
Initial Intermediate Hospital Visit	Internist
Initial Comprehensive Hospital Visit	GP, Internist
Brief Followup Hospital Visit	GP, Internist
Limited Followup Hospital Visit	GP, Internist
Extended Followup Hospital Visit	Internist
Brief Emergency Room Visit	Internist
Limited Emergency Room Visit	Internist
Intermediate Emergency Room Visit	Internist
Limited Consultation	GP, Internist
Extensive Consultation	Internist
Comprehensive Consultation	Internist
Psychotherapy-One Hour	Psychiatrist
Psychotherapy-Half Hour	Psychiatrist
Chiropractic Office Visit	GP, Chiropractor
Initial Psysiotherapy	Physical Therapist
Followup Podiatric Office Visit	Podiatrist
Electrocardiogram (EKG)	GP, Internist
EKG-Interpretation, Report Only	GP, Internist
Arterial Blood Gas Study	Internist
Electroencephalogram (EEG)	Neurologist
Chemotherapy	Internist
Collection of Specimens	Laboratory[1]
Debridement of Nails	Surgeon
Skin Biopsy	Surgeon
Chemocautery	Surgeon
Radical Mastectomy	Surgeon
Open Reduction of Fracture	Orthopedic Surgeon
Arthrocentesis-Major Joint	Orthopedic Surgeon
Arthrotomy	GP, Orthopedic Surgeon
Arthroplasty	Orthopedic Surgeon
Needle Puncture of Bursa	Internist
Bronchoscopy	Internist
Thoracentesis	General Surgeon
Catherization of Heart	Cardiologist

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[1] Without regard to medical specialty or place where service was performed.

Insertion of Pacemaker	Cardiologist
Partial Colectomy	General Surgeon
Appendectomy	General Surgeon
Sigmoidoscopy	GP, General Surgeon
Hemorrhoidectomy	General Surgeon
Cholecystectomy	General Surgeon
Repair Hernia	General Surgeon
Diagnostic Cystourethroscopy	GP, Urologist
Dilation of Urethra	Urologist
Prostatectomy	Urologist
Electrosection-Prostate (TUR)	GP, Urologist
Hysterectomy	Obstetrician-Gynecologist
Initial Complete Eye Exam	Ophthalmologist
Comprehensive Eye Exam	Ophthalmologist
Eye Exam with Tonometry	Ophthalmologist
Extraction of Lens	GP, Ophthalmologist
Chest X-ray-Single View	GP, Radiologist
Chest X-ray-Two Views	GP, Radiologist
X-ray-Spine	Radiologist
X-ray-Hip	Radiologist
X-ray-Colon	Radiologist
Radiation Therapy-Low Volt	GP, Radiologist
Radiation Therapy-Super Volt	GP, Radiologist
Radiation Therapy-Megavolt	Radiologist
CAT Scan-Head	Radiologist
CAT Scan-Head, Interpret Only	Radiologist
Three Chemistry Tests	Laboratory
Twelve Chemistry Tests	Laboratory
Culture-Other than Blood	Laboratory
Hemoglobin	Laboratory
Automated Blood Count	Laboratory
White Cell Count	Laboratory
Complete Blood Count (CBC)	Laboratory
Cholesterol Test	Laboratory
Flocculation Test	Laboratory
Hematocrit	Laboratory
Platelet Count (Rees-Ecker)	Laboratory
Potassium Test	Laboratory
Prothrombin Time Test	Laboratory
Sedimentation Rate	Laboratory
Blood Sugar	Laboratory
BUN-Urea Nitrogen	Laboratory
Uric Acid	Laboratory
Feces-Occult Blood	Laboratory
Pap Test	Laboratory
Routine Urinalysis	Laboratory
Chemical Urialysis	Laboratory
Pathology-Three Specimens	Laboratory

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[1] Without regard to medical specialty or place where service was performed.

HIAA Surgical Prevailing Healthcare Charges

Statistical File

Type of Scale: Charge-Based

The Health Insurance Association of America Surgical Prevailing Charge file is a compilation of 3 million claims contributed by 22 large private insurers. The data are arranged by area and procedure, covering approximately 250 areas nationwide and all recognized 1964 CRVS surgical procedures. The file includes approximately 160,000 area-procedure combinations. For each area-procedure combination the mean and mode charges are given along with the number of claims on which the statistics are based. For area-procedure combinations for which at least 5 claims were processed, the 50th, 60th, 70th, 75th, 80th, 85th, 90th and 95th percentile charges are also given.

The statistics on this file are based solely on private claims, enabling comparisons of RVSs based on public and private claims. Although the data are limited to surgical procedures, the procedures included are of interest because many are costly. The HIAA Surgical Procedure Charge file is available semi-annually, the Urban Institute has obtained a copy of the file covering the period September 1, 1977 to August 31, 1978 and could obtain data for a more recent period. All procedures on the file are identified by the 1964 CRVS.

USC - Mendenhall Practice Study Data

Type of Scale: Time Based

The USC-Mendenhall data base is a large survey of patient encounters. The sample includes approximately 10,000 physicians and 250,000 patient visits observed between 1974 and 1976. In addition to the time spent by the physician with the patient, the physician's role (referral, regular patient, etc.), the complexity, severity and urgency of the patient's problem and up to three diagnoses identified by ICDA codes are listed on each patient visit record. The survey included a checklist of diagnostic and therapeutic procedures likely to be performed by the physician (based on specialty); those ordered or provided for each encounter are identified.

Detailed information is available on patient characteristics and the physicians' practices. The patient information includes age, sex, and a distribution of patients by source of payment. The physician information includes age, experience, type of practice, state, demographic county category, intern and resident flags, board certification and medical school faculty appointment status, specialty and hours spent per week in 11 possible settings (e.g. private office, emergency room). The number of support staff in the practice, including other physicians, x-ray/lab technicians and the grand total, is also available.

Strengths and Limitations

The USC-Mendenhall files are the largest and most detailed available source of information on the contributions of physician time to the provision of medical services. The inclusion of information on diagnoses, diagnostic and therapeutic procedures, and case complexity and severity facilitate the

development of cross references between these data and the procedure specific data identified by CRVS codes.

The major limitations of this data base are the absence of information on the time contributions of staff other than the sample physician, the lack of information on equipment used, and the absence of any charge or price information.

The Urban Institute is in the process of obtaining the USC-Mendenhall data for six specialties: general practice, family practice, internal medicine, pediatrics, obstetrics-gynecology and general surgery. To date, the tapes for internal medicine and general surgery have been received. A copy of the patient encounter form and associated coding sheet follows.

PLEASE REVIEW INSTRUCTIONS BEFORE STARTING

ENCOUNTER LOCATION	1. Office 2. OPD 3. Clinic	4. Hospital 5. Emergency Room 6. Extended Care (ICF, SNF, Nursing Home)	7. Industry/School 8. Home 9. Other

PRIMARY PROBLEM TYPE	1. Preventive 2. Medical 3. Surgical - minor 4. Surgical - major	5. Medical & Surgical 6. Obstetrical 7. Psycho/Social 8. Environmental/Economic

Staff may complete this section

Use numbers from Coding Key

	ENCOUNTER DATE and TIME	PATIENT & ENCOUNTER CHARACTERISTICS										PATIENT'S PROBLEM(S)			DIAGNOSTIC PROCEDURES	THERAPEUTIC PROCEDURES	ENCOUNTER CLASS	STATUS
			Age	Sex			Patient Source	Majority of Care	Your Role			Primary	Other					
Line Number	Mo. Day Yr. Date Time in Minutes	Location (use one of the above codes 1-9)	Estimate to nearest year "0" = under one year	1. Male 2. Female	Seen patient before? 1. Yes 2. No	Regular patient? 1. Yes 2. No	1. Self/Patient 2. Agency 3. Physician 4. Consult	This patient? 1. Yes 2. No 3. Undetermined Patient's family? 1. Yes 2. No 3. Undetermined	1. Provide 2. Assist	Number of visits for this problem?	Type (use one of the above codes 1-8)	Focus Etiology (Dx)	Focus Etiology (Dx)	Focus Etiology (Dx)	Record all ordered, performed, or interpreted	Record all ordered or performed	Complexity Severity Urgency	Your next contact Referral/Consultation
01																		
	Primary Dx (Print)											Other Dx (Print)						
02																		
	Primary Dx (Print)											Other Dx (Print)						
03																		
	Primary Dx (Print)											Other Dx (Print)						
04																		
	Primary Dx (Print)											Other Dx (Print)						
05																		
	Primary Dx (Print)											Other Dx (Print)						

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PART II, SECTION C: PATIENT ENCOUNTERS—OUTPATIENT/INPATIENT

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CODING KEY

FOCUS

1. Well patient
2. Skin, incl. nails and hair
3. Head/Neck
4. Eyes
5. Ears
6. Nose
7. Mouth/Throat
8. Breasts
9. Respiratory - upper
10. Respiratory - lower
11. Circulatory - heart
12. Circulatory - other
13. Blood/Lymphatics
14. Liver/Gallbladder
15. Gastrointestinal - other
16. Arthritis/Rheumatism
17. Muscular - other
18. Skeletal - other
19. Endocrine
20. Neurological
21. Emotional
22. Renal
23. Urinary - other
24. Genital - male
25. Gynecological
26. Obstetrical
27. Multi-system*

*Use only if one of the above is not more descriptive and correct.

ETIOLOGY (DX)

1. None
2. Health assessment
3. Developmental
4. Pre/post-surgical
5. Iatrogenic
6. Idiopathic (based on workup)
7. Infection/post-infection
8. Inflammation
9. Hemorrhaging/Bleeding
10. Occlusion
11. Ulceration
12. Immunologic
13. Allergic
14. Metabolic
15. Deficiencies
16. Nutrition, incl. weight
17. Congenital
18. Degeneration, incl. aging
19. Hypertension
20. Neoplasm - benign
21. Neoplasm - malignant
22. Neoplasm - undetermined

INTOXICATION/ADDICTION

23. Alcohol
24. Drug
25. Poison
26. Tobacco

TRAUMA

27. Burn
28. Concussion
29. Contusion
30. Dislocation/Fracture
31. Foreign body
32. Laceration
33. Sprain

PSYCHO/SOCIAL

34. General adjustment
35. Depression/Anxiety
36. Neuroses
37. Psychoses
38. Psychosomatic

UNDETERMINED

39. Cough
40. Fatigue
41. Fever
42. Headache
43. Malingering
44. Pain

DIAGNOSTIC PROCEDURES

1. None
2. Routine lab: CBC, Urinalysis
3. Serology/VD
4. Blood chemistry
5. "Panel" - automated (e.g., SMA-12)
6. ECG
7. Culture
8. Enzymes
9. Biopsy
10. Bone marrow
11. Endoscopy

RADIOLOGY

12. Chest
13. GI
14. Fluoroscopy
15. Isotopes
16. X-ray - other

OTHER

17. Catheterization
18. EEG
19. Thermography
20. Glucose tolerance
21. Lipid screen
22. Liver function
23. Lumbar puncture
24. Pulmonary function
25. Renal function
26. Thyroid function
27. Breast exam
28. Pap smear
29. Skin test - allergy
30. Skin test - TB/Mycosis
31. Audiometry
32. Tonometry
33. Developmental screen
34. Tests - other

THERAPEUTIC PROCEDURES

1. None
2. Immunizations
3. Injections - other

DISLOCATIONS/FRACTURES

4. Reduction - open
5. Reduction - closed

SURGICAL

6. Minor tissue removal
7. Incision/Drainage
8. Suturing only
9. Debridement
10. Organ removal/repair
11. Foreign body removal
12. Dilation/Curettage
13. Arthrocentesis
14. Paracentesis
15. Catheterization
16. Cauterization/Cryotherapy
17. Surgery - other

POST-SURGERY/INJURY

18. Cast/Splint: apply/remove
19. Dressing: apply/remove
20. Suture removal

OTHER RX

21. Anesthetization
22. Chemotherapy
23. Contraceptives, incl. IUD
24. Physical rehabilitation
25. Radiation therapy
26. Transfusion
27. Rx - other

COUNSELING

28. Growth/Development
29. Family/Social/Sexual
30. Patient education
31. Therapeutic listening
32. Treatment program

PRESCRIPTIONS/ORDERS

33. Drugs - systemic
34. Drugs - topical
35. Exercise/Diet
36. Prosthesis/Aids

ENCOUNTER CLASSIFICATION

COMPLEXITY

1. Minimal
2. Brief
3. Limited
4. Extended
5. Comprehensive

SEVERITY

1. None
2. Minor - acute
3. Minor - chronic
4. Moderate - acute
5. Moderate - chronic
6. Severe - acute
7. Severe - chronic

URGENCY

1. None
2. Could have been deferred
3. Needed to see today
4. Should have seen sooner
6. Emergency

STATUS/DISPOSITION

YOUR NEXT CONTACT

1. None this problem
2. Telephone

OUTPATIENT

3. Return as necessary
4. Visit scheduled
5. House call

INPATIENT

6. At hospital admission
7. On rounds (prior admission)
8. In surgery

OTHER

9. Emergency room
10. Extended care (ICF, SNF, Nursing Home)
11. DOA/Death
12. Other

REFERRAL/CONSULTATION

1. None
2. Return to referral source
3. Medical specialist for care
4. Medical specialist for consult
5. Surgical specialist for care
6. Surgical specialist for consult
7. Dentist
8. Physician Extender (e.g., Medex, Nurse Practitioner, Physician's Assistant)
9. Therapist/technician (e.g., Dietary)
10. Public agency
11. Other

National Ambulatory Medical Care Surveys

Type of Scale: Time based

The NAMC surveys are national probability sample surveys of ambulatory patient office visits. The surveys are performed annually and usually cover 45-50,000 visits sampled in 2,000 physicians' offices. The questions included vary from year to year, but all years include time spent with physician, patient age, race and sex, physician diagnosis (up to 3 may be identified) listed by ICDA code, and whether or not specific diagnostic or therapeutic services were ordered or performed. Physicians are identified by specialty and type of practice and the region and metropolitan/nonmetropolitan status of their office location. Patients on referral, new patients and return (for same problem) visits are flagged.

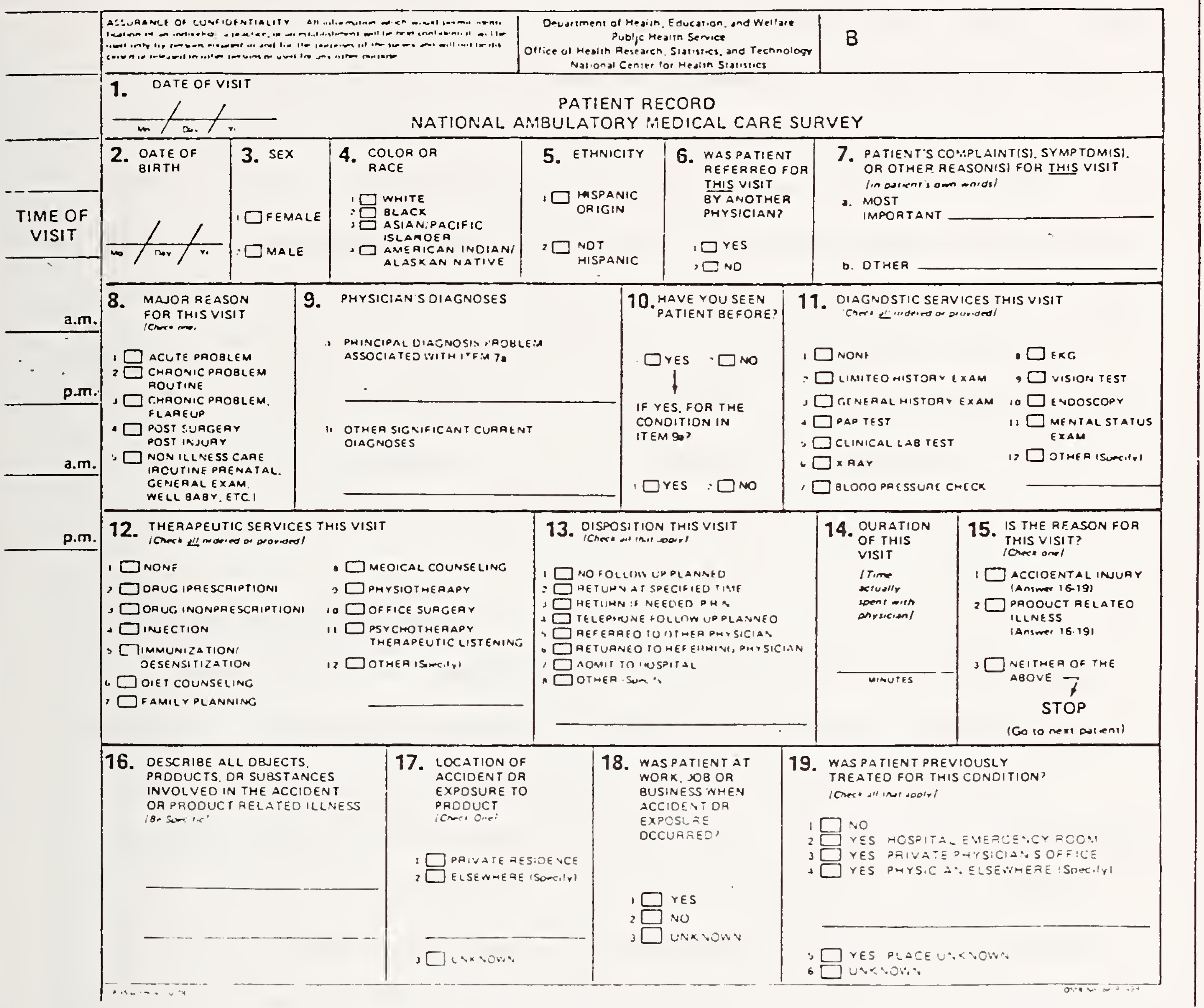
Questions included in some years only include major reason for visit (type of illness - acute, chronic, accident, etc.) seriousness of illness and Hispanic ethnicity of patient.

Strengths and Limitations

The primary advantage of the NAMC data is that similar surveys have been given annually from 1975 to the present. The two limitations concern the identification of the services delivered in the patient encounter. Services ordered by the physician, but performed elsewhere (e.g., physiotherapy) can not be distinguished from services delivered at the time of the visit. In addition the time measure is restricted to time spent with the physician, whereas the services listed could be provided by another staff member. Because of these characteristics the data will be useful for assessing changes in time values over several years, but not particularly useful for

establishing relative values across procedures. A copy of the 1979 patient record form follows.

1979 Patient Record



ASSURANCE OF CONFIDENTIALITY — All information which would permit identification of an individual, a practice, or an establishment will be held confidential, will be used only by persons engaged in and for the purposes of the survey and will not be disclosed or released to other persons or used for any other purpose.

Department of Health, Education, and Welfare
Public Health Service
Office of Health Research, Statistics, and Technology
National Center for Health Statistics

B

PATIENT RECORD
NATIONAL AMBULATORY MEDICAL CARE SURVEY

TIME OF VISIT
a.m.
p.m.
a.m.
p.m.

1. DATE OF VISIT ___/___/___ Mo. / Day / Yr.

2. DATE OF BIRTH ___/___/___ Mo. / Day / Yr.

3. SEX
1 ☐ FEMALE
2 ☐ MALE

4. COLOR OR RACE
1 ☐ WHITE
2 ☐ BLACK
3 ☐ ASIAN/PACIFIC ISLANDER
4 ☐ AMERICAN INDIAN/ ALASKAN NATIVE

5. ETHNICITY
1 ☐ HISPANIC ORIGIN
2 ☐ NOT HISPANIC

6. WAS PATIENT REFERRED FOR THIS VISIT BY ANOTHER PHYSICIAN?
1 ☐ YES
2 ☐ NO

7. PATIENT'S COMPLAINT(S), SYMPTOM(S), OR OTHER REASON(S) FOR THIS VISIT *(In patient's own words)*
a. MOST IMPORTANT ______
b. OTHER ______

8. MAJOR REASON FOR THIS VISIT *(Check one)*
1 ☐ ACUTE PROBLEM
2 ☐ CHRONIC PROBLEM ROUTINE
3 ☐ CHRONIC PROBLEM, FLAREUP
4 ☐ POST SURGERY POST INJURY
5 ☐ NON ILLNESS CARE (ROUTINE PRENATAL, GENERAL EXAM, WELL BABY, ETC.)

9. PHYSICIAN'S DIAGNOSES
a. PRINCIPAL DIAGNOSIS/PROBLEM ASSOCIATED WITH ITEM 7a ______
b. OTHER SIGNIFICANT CURRENT DIAGNOSES ______

10. HAVE YOU SEEN PATIENT BEFORE?
1 ☐ YES 2 ☐ NO
IF YES, FOR THE CONDITION IN ITEM 9a?
1 ☐ YES 2 ☐ NO

11. DIAGNOSTIC SERVICES THIS VISIT *(Check all ordered or provided)*
1 ☐ NONE
2 ☐ LIMITED HISTORY EXAM
3 ☐ GENERAL HISTORY EXAM
4 ☐ PAP TEST
5 ☐ CLINICAL LAB TEST
6 ☐ X RAY
7 ☐ BLOOD PRESSURE CHECK
8 ☐ EKG
9 ☐ VISION TEST
10 ☐ ENDOSCOPY
11 ☐ MENTAL STATUS EXAM
12 ☐ OTHER (Specify) ______

12. THERAPEUTIC SERVICES THIS VISIT *(Check all ordered or provided)*
1 ☐ NONE
2 ☐ DRUG (PRESCRIPTION)
3 ☐ DRUG (NONPRESCRIPTION)
4 ☐ INJECTION
5 ☐ IMMUNIZATION/ DESENSITIZATION
6 ☐ DIET COUNSELING
7 ☐ FAMILY PLANNING
8 ☐ MEDICAL COUNSELING
9 ☐ PHYSIOTHERAPY
10 ☐ OFFICE SURGERY
11 ☐ PSYCHOTHERAPY THERAPEUTIC LISTENING
12 ☐ OTHER (Specify) ______

13. DISPOSITION THIS VISIT *(Check all that apply)*
1 ☐ NO FOLLOW UP PLANNED
2 ☐ RETURN AT SPECIFIED TIME
3 ☐ RETURN IF NEEDED, P.R.N.
4 ☐ TELEPHONE FOLLOW UP PLANNED
5 ☐ REFERRED TO OTHER PHYSICIAN
6 ☐ RETURNED TO REFERRING PHYSICIAN
7 ☐ ADMIT TO HOSPITAL
8 ☐ OTHER (Specify) ______

14. DURATION OF THIS VISIT *(Time actually spent with physician)*
______ MINUTES

15. IS THE REASON FOR THIS VISIT? *(Check one)*
1 ☐ ACCIDENTAL INJURY (Answer 16-19)
2 ☐ PRODUCT RELATED ILLNESS (Answer 16-19)
3 ☐ NEITHER OF THE ABOVE → STOP
(Go to next patient)

16. DESCRIBE ALL OBJECTS, PRODUCTS, OR SUBSTANCES INVOLVED IN THE ACCIDENT OR PRODUCT RELATED ILLNESS *(Be Specific)*
______
______

17. LOCATION OF ACCIDENT OR EXPOSURE TO PRODUCT *(Check One)*
1 ☐ PRIVATE RESIDENCE
2 ☐ ELSEWHERE (Specify) ______
3 ☐ UNKNOWN

18. WAS PATIENT AT WORK, JOB OR BUSINESS WHEN ACCIDENT OR EXPOSURE OCCURRED?
1 ☐ YES
2 ☐ NO
3 ☐ UNKNOWN

19. WAS PATIENT PREVIOUSLY TREATED FOR THIS CONDITION? *(Check all that apply)*
1 ☐ NO
2 ☐ YES HOSPITAL EMERGENCY ROOM
3 ☐ YES PRIVATE PHYSICIAN'S OFFICE
4 ☐ YES PHYSICIAN ELSEWHERE (Specify) ______
5 ☐ YES PLACE UNKNOWN
6 ☐ UNKNOWN

HCFA Physicians Practice Cost Survey

Type of Scale: Statistical Cost Function

The HCFA Physicians Practice Cost surveys are national probability sample interview surveys which provide detailed information on physicians' costs, inputs, outputs, and fees. The surveys were administered by HCFA in 1977, 1978 and 1979. Each survey covered between 3400 and 5800 office based physicians and between 350 and 540 hospital based physicians. A total of 15 specialties are represented. The office-based physicians were asked to report their usual fees and reimbursement levels for 30 procedures, the hospital-based physicians for 8. Each physician, however, provided responses only for those procedures appropriate to his/her specialty. Area-specific socio-economic data have been merged to the physician records.

Strengths and Limitations

These surveys are adequate for the estimation of a statistical cost function. The output measures available for office-based physicians are counts of five types of patient visits (office, house call, hospital, emergency room and nursing home) and operations. The number of each of these services provided in one week is given, and the percent of visits which included lab tests, injections or immunizations, and x-rays is identified. The output measures for hospital based physician are counts of autopsies, lab tests, operations, x-ray interpretations, radiology consultations and inpatient and office visits, also for a one week period. The information on patient characteristics is limited to an insurance coverage distribution. The data on inputs includes a detailed breakdown of the hours spent by the physician on various activities and the number of employees and hours worked

for five categories of support staff. The available price data include the fees mentioned above and wages for support staff by category. Total expenditures for office space, medical equipment, medical supplies and malpractice insurance are available along with total deductible expenses. Total net income is available, therefore gross revenues can be estimated.

All income and expense data is for the full year preceding the survey year. Therefore, it will be necessary to assume that the measures of outputs for one week and the fees reported, which are from the survey year can be used to generate equivalent annual figures for the previous year (or vice versa) which are unbiased. This is the major limitation inherent in these surveys. It is also expected that the data for some specialties will present quality and sample size problems.

In summary, the Physician Practice Cost data is sufficiently detailed to enable an exploratory estimation of a statistical cost function. The data are, however, not ideal for this purpose. The primary limitations are the lack of information on complexity of services provided and the difference in base periods between the output and price data and the expense data.

AMA Periodic Survey of Physicians' Practices

Type of Scale: Not specific

This annual survey conducted by the American Medical Association provides simple statistics on individual physicians' practices. Each physician is identified by specialty, type of practice, region and metropolitan/nonmetropolitan location. The information included varies from year to year, but all recent years' surveys have contained questions regarding the number of patients seen and time worked in the office, in a hospital and elsewhere. All recent years also asked for annual professional expenses and net income estimates. Charge data ("customary usual fees") was requested for new and established patients office visits, annual or periodic examination, appendectomy and hospital visits. The surveys for some years included charges for a few other procedures and/or a five category disaggregation of expenses.

This survey does not seem particulary useful for developing an RVS. Charge data (reported by physician) is only available for a few procedures. The output measures are restricted to numbers of patient encounters by location for one week. The expense data is not detailed enough to be useful.

Mathematica Group Practice Survey

Type of Scale: Not specific

This data base consists of the responses of 5,000 physicians in 2,000 group practices to a survey administered in 1978. The files have records at both the physician and group level and most of the group data is available on each physician record. In addition to the survey data, both types of records have area demographic characteristics and area hospital statistics appended to them.

The group practice data include detailed information on group practice financial arrangements such as total billings, total expenses, methods of distributing income and expenses to individual physicians, and information on non-physician inputs including payroll and equipment.

The sample was limited to five specialties: general practice, internal medicine, pediatrics, general surgery and obstetrics-gynecology. Both single specialty and multispecialty groups, including prepaid practices, are represented. Usual fees for hospital and office visits and a few selected procedures are available for each physician.

The data provide measures of output on an annual basis for the group and for one week for each physician. The most detailed information is for surgical procedures for which the number performed and the range of time required (in minutes) is included for up to 12 H-ICDA codes. The inclusion of time values permits comparison with CRVS codes. Data is also available on patient visits, both to physicians and to nonphysician support staff.

The information on patient characteristics is rather limited, consisting of distributions of insurance coverage, race and income. The physician characteristics identified include specialty, sex, FMG and board certification status, years since graduation and years of residency training received.

Strengths and Limitations

The group practice data, which is in house at the Urban Institute, includes enough information for the estimation of a statistical cost function for office visits. The surgery data could be compared with that available in other data bases. The data on group physicians could possibly be contrasted to those for solos, but are probably of lesser interest due to the predominance of solo practitioners.

The two limitations of these data are the small number of procedures for which fees are reported and the absence of measures of the complexity of outputs.

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